

should be done' Ought we to attempt reduction, or to cut off the projecting part, or to amputate? I would prefer immediate and exact reduction—making free incisions; for the chief danger lies on the side of inflammation and strangulation of the parts beneath the aponeuroses. I would not cut off the projecting bone unless the necessity for doing so were conspicuous; still less would I have recourse to amputation.—*Lond. Med. Gaz. Dec. 15th, 1832.*

29. *Case of Subclavian Aneurism.*—The *Lancet*, for November last, contains an account of a case of subclavian aneurism successfully treated by WILLIAM P. NICHOLS, Esq. of Norwich. The subject of the case was a lady, twenty-one years of age, in whose neck a pulsating tumour appeared immediately after she had subjected her left arm to severe and unusual exertion in saving herself from a fall.

"On examination," says Mr. N. "I found a tumour of the size of a hen's egg, situated in the left side, occupying the triangular space which is bounded below by the clavicle, on the inner side by the clavicular portion of the mastoid muscle, and on the outer side by the anterior fibres of the trapezius, evidently the result of some injury done to the subclavian artery in that part of the canal which stretches from the edge of the scalenus muscle towards the axilla, before it has passed under the clavicle; indeed, so near the edge of the scalenus was the injury, that I was not able to compress the vessel with my thumb, between the muscle and the tumour.

"The aneurismal nature of the swelling being very evident, I did not think it desirable at that time to apprise the patient of the formidable character of the tumour; but, directing her to remain quiet, I gave her some aperient medicine, promising to see her again in a few days, when I explained to her fully her situation, and the mode of treatment which I proposed to adopt; she assented, and the operation of securing the vessel above the aneurism was performed in the following manner:—

"*April 30th, eleven A. M.*—The patient was placed in an horizontal position on a table about three feet in height, having her head hanging over the end, and supported by an assistant. The integuments being drawn down, an incision was then made through the skin and platysma myoides, along the clavicle, three inches in length, from the outer fibres of the clavicular portion of the sterno-cleido-mastoideus, outwards: another incision was carried from the inner point of the former one, upwards along the clavicular portion of the sterno-cleido-mastoideus for four inches; this incision passed between the fasciculi of the platysma myoides, which, in this case, were remarkably large. The triangular flap formed by the two incisions, was dissected back, carrying with it, imbedded in its substance, the external jugular vein, as far as the tumour would allow of its being done; and a little dissection now brought into view the omo-hyoidens at the upper part, passing obliquely upwards to its insertion. This muscle was divided, and a small artery passing across the wound immediately below it, was secured; the deep fascia of the neck was here exposed, having on the inner side the middle scalenus beautifully distinct, and passing to its insertion into the tubercle of the rib. By slightly rotating the head, the different direction of its fibres from those of the sterno-cleido-mastoideus, became remarkably apparent, showing how important at this stage of the operation it is, that this muscle should be your guide. The fascia was then cautiously divided along the outer edge of the scalenus, and the transverse artery of the neck drawn upwards by a blunt hook, whilst the large vein which accompanies it, but which crosses the wound considerably lower down, was secured by two silk ligatures and divided. This enabled me to pass my finger along the scalenus to the tubercle of the rib, and to compress the artery where it leaves the chest, about half an inch above that process. The space, however, between the aneurismal tumour and the scalenus was so small, that it was thought advisable to divide a few of its fibres, in order the more readily and securely to tie the vessel. This having been done, a strong blunt aneurismal needle armed with a silk li-

gature was very readily passed under the artery from below, and its blunt extremity having been pressed upwards, I cut through the cellular tissue upon it, and thus passed the instrument without detaching the vessel from its connexions. The ligature was tied with great ease, and the tumour immediately subsided. All pulsation ceased from that time; the edges of the wound were brought together by means of a suture and some adhesive plaster, and the patient returned to her bed. She bore the operation with remarkable firmness throughout."

Nothing requiring notice subsequently occurred. The ligature on the artery came away on the 20th of May, and up to the date of the report, (November,) the patient had enjoyed perfectly good health, and felt no inconvenience from the operation.

The following circumstances Mr. N. considers of some importance:—

"*The position of the patient*, who was placed horizontally, with the head, (as described,) hanging over the end of the table, which position contributed very materially to facilitate the different steps of the operation. The space is thus completely exposed; the light falls fully on the part where it is of the most importance; and the operator is not confused by the presence of any accumulation of blood at the bottom of the wound.

"*The turning back of the jugular vein imbedded in the flap*, thus placing it beyond the chance of injury at the time of, or subsequently to, the operation.

"*The practicability of performing this operation without detaching the sterno-cleido-mastoid muscle from its clavicular origin*, although the tumour was situated above the clavicle.

"*The drawing upwards of the transverse artery*, and thus leaving it undivided, by which this vessel, (becoming enlarged as the circulation in the extremity grows more free,) becomes one of the principal trunks in subsequently supplying blood to the limb.

"*That no unfavourable symptoms* were produced by the division of, and tying, the accompanying vein, which in this instance could not be avoided.

"*Lastly, the passing the aneurismal needle under the vessel, without separating it from its connexions, which may be readily effected; and of tying it beneath the outer fibres of the scalenus*, which fact appears to me valuable, inasmuch as it proves, that the very short distance between the ligature and the thyroid axis, affords sufficient space for the formation of a coagulum, and the consequent obliteration of the arterial tube."

30. *Clinical Lecture of M. Dupuytren on Retraction of the Fingers.*—M. DUPUYTREN, several months ago, directed the attention of his pupils to the subject of permanent flexion of the fingers, and the different causes of the deformity. Writers, in general, have only treated of that species of flexion of the fingers which is occasioned by hardened cicatrices from burns on the palm of the hand. M. Boyer, in his work on Surgery, briefly refers to the subject, and attributes the retraction of the fingers to a *crispatura tendinum*. The real causes and proper treatment of such cases were unknown, until M. Dupuytren discovered that the presumed contraction of the tendons was nothing more than contraction of the palmar aponeurosis, the division of which would immediately remove the deformity. At this time there was every reason to believe that this affection of the aponeurosis was accidental; the causes of it appeared evident, inasmuch as it existed usually in persons who were obliged to make frequent and violent efforts with the palm of the hand. Additional facts, however, have shown that this contraction of the aponeurosis may be not only congenital, but also hereditary. In July, M. Dupuytren was consulted in the case of a child, six years of age, who had a permanent retraction of the little and ring fingers. There were no traces of cicatrix or burn; but, when the fingers were forcibly bent backwards, the extended aponeurosis raised the skin like a tight cord, and left no doubt as to the diagnosis. In this instance the deformity was congenital;